

# Kittery Recreation Department Medical Information Form

Please print clearly in ink and one form per person:

Date:

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ Age: \_\_\_\_\_ Male / Female

City, State, Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Parent/Guardian Name 1: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Parent/Guardian Name 2: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Name and phone # of **person to be contacted when a parent/guardian is unavailable** in event of an emergency:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

First Name:

Allergies - Food, insect, bees, medication, other - please list : \_\_\_\_\_ none

**Medications** - Please list any current medications and the condition for which they are taken (including medications taken during the school year): \_\_\_\_\_ none

**Past Pertinent History** – Heart, Diabetes, Epilepsy, Asthma, etc. - please list below: \_\_\_\_\_ none

**Physical Conditions** - Are there any physical conditions, injuries, or disabilities, which might limit physical activities? \_\_\_\_\_ none

Last Name:

**Primary Physician** - Please provide name, address, phone number and hospital preferences:

\_\_\_\_\_ Hospital Preference \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy# \_\_\_\_\_

Name of minor child: (if applicable), \_\_\_\_\_

Name of Parent/Legal Guardian: \_\_\_\_\_

By signing below I do hereby authorize Kittery Recreation Department, its representatives and employees, to obtain necessary information, evaluation and treatment of the above named, as it be necessary to assist the participant. I certify that this document is true and accurate and I agree to advise the Kittery Recreation Department, in writing, of any change in the medical condition of the above person. I understand that unless the Kittery Recreation Department hears from me otherwise, they will assume that all medical information is unchanged from the date of this agreement. I understand that I am responsible for payment for any medical injuries, if I am not insured or my insurance company does not pay the entire bill in full.

Signature of Person/Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_